KANSAS HEALTH INSTITUTE

MEMO

To: Andy Allison, Deputy Director
Kansas Health Policy Authority

From: Bob St. Peter

Date: August 17, 2007 (edited on 9/21/07)

Re: Memo on consumer directed health purchasing in Medicaid

Andy: you asked that KHI pull together some information summarizing the research on consumer directed health purchasing, and health opportunity accounts in particular, in the Medicaid program. You also wanted a summary of what other states are doing and some highlights of the main issues for states to consider in implementing such programs. This memo, prepared by Jessica Hembree, Sarah Fizell and me, begins to address these issues with the relatively short amount of time that we had. Consider it a first installment. After you review this memo, and we get input from members of the premium assistance working group, we will have a better idea precisely what additional information might be useful and we can pull that together. Thanks, Bob

CONSUMER DRIVEN HEALTH PURCHASING AND MEDICAID

The advent of consumer directed health purchasing (CDHP), including Health Savings Accounts (HSAs) in the private market and Health Opportunity Accounts (HOA) in the Medicaid market, has been touted as the "new new thing" in health care. This memo summarizes the information that is known about the impact of these accounts on cost containment, utilization of preventive care, quality of care, and the insurance market. HSAs are a recent creation, and due to their tax benefits, they have mostly been used by middle and high income individuals, so most available research does not reflect the likely experiences of low-income HSA participants. Furthermore, experience with HOAs among Medicaid beneficiaries is an even newer phenomenon and there is very little good research on this population. Where possible, issues specific to Medicaid beneficiaries are differentiated from those among the general population. Caution should be used in generalizing experiences among higher income persons participating in CDHP to lower income persons who are enrolled in Medicaid.

COST-CONTAINMENT

General Population

Most employees who participate in a CDHP are offered a high-deductible health plan (HDHP) and accompanying HSA that has tax-preferred status. Since employees are responsible for all health care costs up to the amount of the deductible and a significant coinsurance rate after the deductible is met, they have a strong financial incentive to contain their health care costs.

Supporting Evidence:

- In October 2005, the Employee Benefit Research Institute (EBRI) collaborated with the Commonwealth Fund to survey CDHP beneficiaries about their satisfaction with their plan, utilization of services, and awareness of cost and quality when purchasing health services. Since this survey was targeted at employers and administered via the internet, respondents are more likely to be middle and upper-income, so their experiences do not necessarily generalize to lower income persons that could be included in a Medicaid CDHP plan. Nonetheless, the 2005 EBRI survey found that CDHP/HDHP beneficiaries were significantly more likely to: check whether their plan would cover care, talk to doctors about treatment options and costs, ask doctors to recommend less costly prescriptions drugs, and check the price of services.[1]
- In a 2006 survey by the Kaiser Family Foundation, 71% of respondents who were in CDHPs agreed with the statement that "The terms of my health plan make me consider cost when deciding to see a doctor or fill a prescription." Only 49% of non-CDHP respondents agreed with that statement. CDHP beneficiaries were

[1] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.

also substantially more likely to report the use of cost control strategies including asking the doctor for lower cost alternatives, asking about the cost of a visit before making an appointment, and choosing a lower cost option for a recommended test or treatment.[2]

- In a review of five studies that attempted to determine the cost-savings of moving individuals from traditional coverage to an HDHP, researchers conclude that moving everyone in traditional health care plans to an HDHP would result in a one-time reduction in use of 4-15 percent.[3]
- In 2001, Humana provided employees with the option of enrolling in a health reimbursement account (HRA), a predecessor to HSAs. Annual cost increases for its health plan decreased to 4.9% in 2002 and 2.7% in 2003. As a point of comparison, the average cost increase trend in the Louisville market (where Human is headquartered) was 15%. Humana's Chief Actuary suggested that the relatively low cost increases are due to: employees choosing lower cost options, decreased emergency room usage and increased physician office visits and prescriptions, more employees waiving coverage, and some benefit cutbacks. Adjustments were not made to account for benefit cutbacks that accompanied the shift toward HRAs. [4]
- Aetna studied HRA effects on employees at 19 different employers and found that HRA plan enrollees had a 1.5% annual increase in medical claims, compared with double-digit increase for a matched cohort in non-HRA plans. Much of this was due to a reduction on pharmacy costs for HRA beneficiaries, particularly a decline in overall prescriptions and an increase in the utilization of generic drugs. Adjustments were not made to account for benefit cutbacks that accompanied the shift toward HRAs.[5]

Opposing Evidence:

- One of the biggest impediments to encouraging price sensitivity among consumers is the lack of available cost and quality information. The 2005 EBRI survey sought to determine how accessible this type of information was to CDHP plan members. In most cases, CDHP and HDHP beneficiaries are as likely or less likely to have access to needed information as comprehensive health plan beneficiaries. For example, 16% of CDHP/HDHP beneficiaries responded that their health plan provides information on the quality of care provided by doctors, compared to 14% of comprehensive plan beneficiaries. Regarding cost, 16% of comprehensive plan members reported that their health plan provides information

[2] Kaiser Family Foundation, National Survey of Enrollees in Consumer Directed Health Plans. November 2006.
[3] Melinda Beeuwkes Buntin et al., Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality. *Health Affairs*, w516 October 24, 2006.
[4] Testimony of John Bertko before the Joint Economic Committee, Feb. 25, 2004.
[5] Aetna HealthFund Study, Aetna Press Release, Feb. 16, 2004.

on cost of care provided by doctors, compared to just 12% of CDHP/HDHP beneficiaries.[6]

- The 2005 EBRI survey suggests that CDHP may not offer overall cost containment (in contrast to employer health care costs). Despite similar rates of health care utilization, individuals with CDHP plans are significantly more likely to spend a larger share of their income on out-of-pocket expenses than those in comprehensive plans. Of individuals in high deductible plans, 42% spent 5% or more of their income on out of pocket health expenses and premiums. The same was true for 32% of individuals in consumer-directed health plans, but only 12% of individuals in comprehensive health plans.[7]

Medicaid Population

In the context of Medicaid reform, there are some reasons to believe that cost-savings may not be as large as in the private sector. Since beneficiaries will be paying for the up-front deductible costs with Medicaid funds, not their own money, the financial incentives may not be as great. Furthermore, they may be motivated to spend larger portions of the deductible amount if the incentives for saving are not present (e.g., availability of funds after leaving the Medicaid program; federally required reductions in account balance upon leaving the program, etc.).

On the other hand, if Medicaid recipients are allowed to keep the unexpended funds in their HOAs for up to three years, even if discounted 25% (this is specified by the Deficit Reduction Act (DRA)), and are able to use the money on future health care expenses, education costs, or job training, they may experience effective incentives that encourage cost-conscious health care spending.

If Kansas incorporated CDHP into the Medicaid program, most participants would be healthy children and adults, again as required by DRA. Although these individuals make up a substantial percentage of Medicaid beneficiaries, they are responsible for a much smaller proportion of Medicaid costs. Most of the Medicaid expenditures come from coverage of other populations which would be excluded from participating in Health Opportunity Accounts, like the aged and disabled. Therefore, the net impact on Medicaid spending may be less than expected.

There would obviously be administrative costs of implementing such a program that would need to be considered in the overall fiscal impact of the program. For example, the DRA requires states that implement Health Opportunity Accounts to develop an electronic monitoring and funds transfer system for the use of monies in the accounts (i.e., cash is not involved).

[6] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.
[7] Ibid.

UTILIZATION OF PREVENTIVE CARE

General Population

Under a CDHP model, individuals are responsible for a larger share of the costs of their health care. How to ensure that this does not provide a disincentive to the timely receipt of preventive and necessary primary care is an important consideration. Patients may be more influenced by the payments from their HSA in the short-run, than the potential for cost savings years down the road. Another aspect of this is the potential for providing incentives for the use of preventive care. What is the evidence that financial incentives can influence the use of preventive services?

Supporting Evidence:

- Several literature reviews conclude that providing positive incentives for simple behaviors, such as preventive care, appears to be effective.[8] For example, in 1997, Mercy Health Plan, a Philadelphia managed care organization, achieved a statistically significant increase in children receiving all their immunizations by giving parents a $10 gift certificate once the child was fully immunized.
- Uniprise, a UnitedHealth Group Company, conducted a study of care patterns among 250,000 Definity Health plan members who participated in a consumer-directed health plan compared to members enrolled in traditional health plans. The study found that members of a CDHP received preventive and evidence-based care at the same or higher rates as members of traditional plans. In particular, CDHP plan members were 16% more likely to have a cervical cancer screening, 10% more likely to receive a cholesterol screening, and 16% more likely to receive prostate cancer screening. Information provided by Uniprise indicates that the two populations were similar in age and prevalence of chronic conditions.[9] It is worth noting that this study included persons covered by private health insurance and not specifically low income or Medicaid populations.
- Several studies report increased use of preventive care in CDHP and increase compliance with prescribed treatment regimens.[10]

Opposing Evidence:

- Despite a body of evidence demonstrating the effectiveness of positive incentives in changing certain health behaviors, there are some important limitations to this

[8] Robert L. Kane, et al., A Structured Review of the Effect of Economic Incentives on Consumers' Preventive Behavior. *American Journal of Preventive Medicine*, 24:4 (2004)
R Jepson et al., The Determinants of Screening Uptake and Interventions for Increasing Update: A Systematic Review. *Health Technology Assessment*, 4:14 (2000).
[9] Uniprise. Quality of Care: Executive Summary. April 23, 2007.
[10] Melinda Beeuwkes Buntin et al., Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality. *Health Affairs*, w516 October 24, 2006.

finding. There is very little evidence to suggest that incentives actually get people to stop smoking[11] or lose weight.[12]

Medicaid Population

When faced with higher out-of-pocket expenses, there is evidence that low-income individuals cut back on both appropriate and inappropriate health care, including preventive services. [13] Preventive services are typically "carved-out" of the HDHP/HSA, meaning that they are provided without being subject to the deductible amount. Under this scenario, beneficiaries will not face out-of-pocket expenses for preventive services, removing any disincentive to receive them.

QUALITY OF CARE

General Population

Because CDHP encourages greater price sensitivity, it is believed to also encourage consumers to more thoughtfully choose the health care services they consume. This means choosing appropriate care over inappropriate care and evidence-based care over less proven treatment methods. Since consumers have real money on the line, they experience incentives to choose the health care services that will deliver the best health care at the lowest price. Theoretically, this increased price awareness among CDHP participants would benefit even those individuals who are not in CDHP plans, because expenditures would increase at a less severe rate.

As consumers regain awareness of the costs of the health care they consume, there is a risk that this cost-consciousness may affect their use of both necessary and unnecessary services. This might occur because of a general tendency to spend less in response to the incentives, or because individuals do not have the knowledge and skills to differentiate between appropriate and inappropriate care. While there is compelling evidence that consumer directed health care positively impacts individual's cost and quality-consciousness, there is conflicting evidence about the effects of consumer-direction on appropriate utilization of health care and the end effect on health outcomes.

Supporting Evidence:

- One study found that CDHP beneficiaries are more likely to forgo care for less serious health problems, but are not more likely to forgo necessary care.[14]

[11] Rebecca J. Donatelle et al., Incentives in Smoking Cessation: Status of the Field and Implications for Research and Practice with Pregnant Smokers." *Nicotine and Tobacco Research*, 6:2 (April 2004).
[12] U.S. Preventive Health Services Task Force, Screening and Interventions to Prevent Obesity in Adults, December 2003.
[13] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.
[14] V. Agrawal et al., Consumer-Directed Health Plan Report – Early Evidence is Promising, June 2005. Available at www.mckinsey.com/clientservice/payorprovider/health_plan_report.pdf

- Cost sharing reduced the use of the emergency room for less urgent problems to a greater extent than for more urgent problems. Additionally, cost sharing did not reduce the consumption of care regarded as highly effective for nonpoor children. However, for poor children, increased cost-sharing did reduce the consumption of appropriate care.[15]
- For prescription drugs, cost-sharing through CDHP results in a decrease in usage, including among low-income beneficiaries. For example, among individuals making less than $50,000, 27% of comprehensive health plan beneficiaries, and 32% of those with high deductible health plans, had not filled a prescription due to cost.[16] This difference was not statistically significant.

Opposing Evidence:

- The RAND study found that increased cost sharing reduces health care use for both appropriate and inappropriate care. [17]
- The RAND study found that co-payments did not adversely impact the health outcomes of middle and upper-income participants but did lead to poorer health in low-income participants. Higher co-payments lead to a reduction in "episodes of effective care" among low-income adults and children leading to poorer health status. For example, the RAND study found that co-payments increased the risk of death by 10% for low-income adults at risk of heart disease.[18]
- One survey reports that people with HSAs "were significantly more likely to avoid, skip, or delay health care because of costs than were those with more comprehensive health insurance, with problems particularly pronounced among those with health problems or incomes under $50,000."[19]
- Several studies find that those in CDHP plans are more likely to adopt cost-saving behavior that might harm them.[20]

---

[15] Joseph P. Newhouse. Consumer-Directed Health Plans and the RAND Health Insurance Experiment. *Health Affairs.* Volume 23, Number 6, p. 107.

[16] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.

[17] Joseph P. Newhouse. Consumer-Directed Health Plans and the RAND Health Insurance Experiment. *Health Affairs.* Volume 23, Number 6, p. 107, Nov/Dec 2004.

[18] Joseph Newhouse, Free for All? *Lessons from the Rand Health Insurance Experiment,* Harvard University Press, 1996.

[19] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.

[20] J. Greene et al., Consumers' Use of Health Care Decision Making Tools and Cost-Conscious Decision Making, (Paper presented at the National Academy for State Health Policy's Eighteenth Annual State Health Policy Conference, Consumer Directed Health Care: Research Findings and State Policy Implications, Nashville, Tennessee, August 7, 2005).

K. Davis et al., How High is Too High? Implications of High Deductible Health Plans, Pub. no. 816 (New York Commonwealth Fund, April 2005).

Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.

- In the 2005 EBRI survey, 20% of those in CDHP did not fill a prescription due to cost, compared to 16% of those with comprehensive coverage. For all income ranges, 20% of CDHP beneficiaries had skipped doses to make a medicine last longer, compared to 15% of comprehensive plan beneficiaries. This effect is still pronounced for lower income beneficiaries. Of those making less than $50,000 annually, 28% of CDHP beneficiaries had skipped doses of medication to make it last longer, compared to 21% of comprehensive insurance beneficiaries.[21]
- According to the EBRI survey, individuals with comprehensive health insurance were more satisfied with their plan than individuals in HDHPs, with or without accompanying HSAs.[22]

Medicaid Population

Because Medicaid beneficiaries would be paying for services under the deductible using government (or employer) contributions, they may experience fewer incentives to reduce the consumption of both necessary and unnecessary health care. Given the demographics of the Medicaid enrollees, experts recommend a heavy emphasis on education, outreach, and quality initiatives to help beneficiaries distinguish between necessary and unnecessary care seems prudent to help ensure appropriate health care utilization in the context of CDHP. Many of the state plans that are emerging include the availability of health counselors to assist in the selection of health plans to better understand available services and incentives.

IMPACT ON HEALTH INSURANCE MARKET

General Population

There are some persistent concerns about the role of CDHP in promoting adverse selection. This could occur because those individuals who are healthiest and least likely to need expensive health care in the coming year would be predisposed to choose an HDHP/HSA. As these healthy individuals opt into high deductible health plans with health savings accounts, the pool of beneficiaries left in the traditional health insurance plans will consist of a higher proportion of older and sicker individuals who do not choose the HDHP/HSA options because they anticipate significant health care costs in the coming year.[23]

As a result of adverse selection, insurance companies would charge higher prices for HMO and PPO plans because beneficiaries represent a less healthy and more risky pool.

---

[21] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.

[22] Ibid.

[23] Dwight McNeil, Do Consumer-Directed Health Benefits Favor the Young and Healthy? *Health Affairs,* vol 23, no. 1, Jan./Feb. 2004, pp. 186-193.
Employers generally expect consumer-driven health plans to attract healthier-than-average workers. John Gabel, et al., Employers' Contradictory Views About Consumer-Driven Healthcare: Results From A National Survey, *Health Affairs,* Web exclusive, W4, Apr. 21, 2004, pp. 210-218.

There are strategies to offset these effects, such as combining risk pools for all health insurance options or limiting free movement between plan options.[24]

Even with effective risk adjusting, insurance companies may "cherry pick" beneficiaries whose predicted utilization is lower than their monthly allocation based on risk adjustment. Cherry picking can create access problems for those people whose expected health care needs exceed their monthly allocation. Stop-loss arrangements may help reduce the concern of insurers about attracting high-cost beneficiaries. While theories abound, there is relatively little empirical information about risk selection resulting from CDHP.

Supporting Evidence:

- Risk adjustment is most effective when it is done across a pool of individuals, rather than a single person. The most sophisticated risk adjustment methodologies explain only about 20% of the cost variation within a rating category. The insurance model of consumer direction is better-suited to accurate risk adjustment because these models pool beneficiaries, rather than attempting to develop individualized risk assessments.[25]

Opposing Evidence:

- The 2005 EBRI survey suggests that adverse selection has already begun to occur in consumer directed health plans among the broader population. Among CDHP beneficiaries, 57% self-reported being in excellent or very good health, compared to only 45% of comprehensive plan beneficiaries.[26]
- Studies find little difference between the demographics of CDHP enrollees and traditional health plan enrollees, except that CDHP enrollees have higher incomes. Additionally, health care use by CDHP enrollees prior to enrolling was less than the use by those individuals who remain in traditional plans.[27]

Medicaid Population

If the state Medicaid agency self-finances a health care plan, adverse selection will not impact the overall cost of coverage and becomes less important.

[24] Bob Lyke, et al., Health Savings Accounts, CRS Report for Congress, September 24, 2004.
[25] Charles Milligan et al., Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing, AcademyHealth State Coverage Initiatives, January 2006.
[26] Paul Fronstin et al., Early Experience with High-Deductible and Consumer-Drive Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey. EBRI Issue Brief No. 288. December 2005.
[27] L.A. Tollen et al., Risk Segmentation Related to the Offering of a Consumer-directed Health Plan: A Case Study of Humana, Inc., Health Services Research 29, no.4, Part 2 (2004): 1167-1188.

LESSONS FROM OTHER STATES

Since most state efforts have only recently been approved by CMS, we have very little information about how the reforms have impacted the cost, quality, access, and outcomes of the Medicaid program. The only state with significant information available is Florida, and even that is limited (see below). One meta-analysis attempted to address the anticipated effects of limited coverage plans implemented under Health Insurance Flexibility and Accountability (HIFA) waivers. The analysis found that beneficiaries experienced significant gaps in health care and serious health care shortages. More than three quarters reported health care needs beyond their coverage.[28] Nonetheless, states are pressing ahead with Medicaid reforms based on the principles of CDHP and careful analysis will be necessary to fully understand both the advantages and disadvantages of this approach.

[28] "Can States Stretch the Medicaid Dollar"

STATES OPERATING PREMIUM ASSISTANCE PROGRAMS

	State	Benefit Package	Enrollment as of July 2006	Eligibility
Section 1906 (HIPP)	Missouri	Medicaid benefits	8,640	All Medicaid eligible individuals, i to be cost-effective
	Georgia	Medicaid benefits	N/R	All Medicaid eligible individuals
	California	Medicaid benefits	N/R	Must be on MediCal, have a high condition and be cost-effective
	Iowa	Medicaid benefits	4,400	All Medicaid eligible individuals
	Pennsylvania	Medicaid benefits	22,600	All Medicaid eligible individuals
	Rhode Island	Medicaid benefits	5,500	Parents to 185% FPL, children to FPL
	Texas	Medicaid benefits	11,912	All Medicaid eligible individuals
Section 1115 (HIFA)	Arkansas	A limited encounter benefit package.	116[29]	Parents, spouses and adults to 2
	Idaho	Parents can choose to enroll children in SCHIP or their employer sponsored insurance plan. Parents who work at small businesses can receive premium assistance to buy into their employer-sponsored plan.	456	Adults and children to 185% FPL
	Illinois	Employer health plan benefits must include physician services and inpatient hospitalization	4,922	Children and parents to 185% FP
	Oklahoma	Benefits are dependent upon provider selected by employer group or individual enrollee	712[30]	Adults to 185% FPL
	Oregon	Employer plan must meet or exceed the state-established benchmark for subsidized employer coverage.	5,300	Adults and children to 185% FPL
	New Mexico	State-designed benefit package	4,700	Adults to 200% FPL
	Utah	Employer health plan benefits	75	Adults to 150% FPL
Sections 1115 and 1906	Maine (HIFA)	DirigoChoice is an affordable health insurance option for small businesses and the self-employed.	13,300[31]	Childless adults to 100% FPL
	Massachusetts	The basic benefit level (mandated for all small employers in the state) is the benchmark against which employer health plans are evaluated. Children and parents below 150% receive Medicaid benefits.	18,973	Children and adults to 200% FPL
	New Jersey (HIFA)	Medicaid eligibles in the fee-for-service program only (high cost cases) receive Medicaid benefits. Children to 150% FPL receive Medicaid benefits. Children between 150 and 350% FPL and parents to 200% FPL receive a commercial package that is benchmarked to the health plan most commonly sold to small employers.	770	Families to 200% FPL, children t FPL
	Virginia (HIFA)	Parents can choose to enroll children in SCHIP or their employer sponsored insurance plan.	1,629[32]	Children to 200% FPL
	Wisconsin	Medicaid benefits	1,691[33]	Children to 200% FPL, families t FPL

(Based on table from *Premium Assistance in Medicaid and SCHIP; Ace in the Hole or House of Card?* July 17, 2006. Issue Brief No. 812, National Health Policy Forum. Washington, D.C.)

[29] As of July 2007.
[30] As of May 2006.
[31] As of Dec. 1, 2006.
[32] As of May 2006.
[33] As of May 2006.

SELECTED CASE STUDIES OF STATES IMPLEMENTING CDHP AND/OR PREMIUM ASSISTANCE PROGRAMS

FLORIDA

Florida's Section 1115 Medicaid demonstration waiver was approved by the U.S. Department of Health and Human Services (HHS) on October 19, 2005. In this demonstration, which was approved by the Florida legislature and is now being implemented, Medicaid beneficiaries are assigned a risk-adjusted premium, based on their health status and historic use of services. With this premium, the beneficiaries will purchase coverage from state-approved managed care plans. The state will regulate plans to ensure actuarial equivalence among the plans and sufficiency of benefits; many different benefit and cost-sharing arrangements may emerge in the different products offered to Medicaid beneficiaries by the insurance plans.

A "Choice Counselor" will advise beneficiaries in choosing a plan. In each plan, there will be a comprehensive care component, in which the insurers assume the risk, and a catastrophic care component, in which the insurer may choose whether or not to assume the risk in accordance with criteria established by the state. The state will establish an overall maximum benefit for all recipients except children under age 21 and pregnant women. Beneficiaries may "opt out" of a Medicaid-approved plan and use their allocation to purchase insurance through their employer. Beneficiaries will also be given an Enhanced Benefits Account, in which the state will deposit funds to reward healthy behaviors, such as weight management, smoking cessation, and diabetes management. These funds could be used for health care related expenses.

Initially, the program will be mandatory for Temporary Assistance for Needy Families (TANF) and Aged and Disabled eligibility groups. Current income and asset limits for enrollment will apply. The program was phased in by county, beginning with Broward (Ft. Lauderdale) and Duval (Jacksonville). The state will establish a low-income pool to provide direct payments to safety-net providers to subsidizecare to the uninsured. Growth in state Medicaid expenditures will be tied to growth in state revenues rather than historic growth in Medicaid, thereby both constraining the growth of the Medicaid budget and making it more predictable.[34]

Preliminary research, largely emanating from critics of the program in Florida, suggests:

- Provider participation in Medicaid appears to be declining post-reform. More than one-fourth of physicians participating in Medicaid prior to the pilot reform program and responding to the Institute's survey indicate that they do not intend to participate in pilot program plans. Subsequent interviews with providers revealed two key areas that affected their decisions about participating in

[34] Excerpted from Milligan, Charles, et al., Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing. State Coverage Initiatives. January 2006.

Medicaid: concerns about low reimbursement levels and the potential for increased administrative burdens.[35]

- Children are the single largest group enrolled in reform plans, and their access to care may be worsening. About half of doctors surveyed (51%) report that it is now harder for them to provide medically necessary services to children because of restrictions and requirements of the pilot program plans.[36]
- Both doctors and patients report frustration with the complexity of the new system, which requires beneficiaries to choose from among multiple health plans with differing benefits.[37]
- Half of the HMOs participating in the reform pilot are using the new benefit flexibility offered under reform to limit their drug benefit. Seven out of 14 reform HMOs limit the number or dollar value of prescriptions that can be filled.[38]
- Virtually all reform HMOs include fewer commonly prescribed drugs on their preferred drug lists than the existing Medicaid program does in the rest of the state. Preferred drug lists are used to encourage appropriate drug use and to reduce drug costs. The barriers created for obtaining drugs not on the list may be reasonable for those who can be safely switched to alternate medications, but for others – especially those with mental illness – the barriers can prevent access to the drugs that allow them to stay healthy.[39]
- Making informed choices about plans based on drug needs is proving to be challenging for beneficiaries. In focus groups, beneficiaries reported that access to drugs is an important basis for choosing a plan, but choice counselors are unable to help beneficiaries determine which plans cover their drugs or whether covered drugs will be dispensed without restrictions. Nor is it easy to get information on plans' preferred drug list by phone or on the web. Even if the information is available, it can be hard to find a plan that includes all of a patient's drugs on its preferred drug list.[40]

[35] Jessie Ball DuPont Fund, Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes, May 2007.
[36] Jessie Ball DuPont Fund, Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes, May 2007.
[37] Jessie Ball DuPont Fund, Waving Cautionary Flags: Initial Reactions from Doctors and Patients to Florida's Medicaid Changes, May 2007.
[38] Jessie Ball DuPont Fund, Uncertain Access to Needed Drugs: Florida's Medicaid Reform Creates Challenges for Patients, July 2007.
[39] Jessie Ball DuPont Fund, Uncertain Access to Needed Drugs: Florida's Medicaid Reform Creates Challenges for Patients, July 2007.
[40] Jessie Ball DuPont Fund, Uncertain Access to Needed Drugs: Florida's Medicaid Reform Creates Challenges for Patients, July 2007.

The following states are all operating under new flexibility provided by the DRA (note: most of the information that follows was taken directly from the CMS website which posts state plan amendments approved under DRA)

IDAHO

In 2006, Idaho undertook substantial Medicaid reform. Idaho's separate SCHIP program became a Medicaid look-alike and the three Benchmark Benefit packages were approved by CMS under DRA. This allowed the state to divide the Medicaid and SCHIP populations into three major categories. The alternative benefit packages include a Basic Benchmark plan for low-income children and working-age adults, an Enhanced Benchmark plan for individuals with disabilities and special medical needs and a special Coordinated Plan for the elderly. All packages are voluntary alternatives to traditional Medicaid. Enrollment will occur only after beneficiaries are advised of the differences in coverage and informed that they may opt out and return to traditional Medicaid at any time.

Basic Benchmark Benefit Package for Low-Income Children and Working-Age Adults

- Consists of healthy children and healthy working-age adults
- This benchmark package provides "basic coverage" to over 80% of the Idaho Medicaid population.
- Covers most of the current Medicaid State Plan benefits with the exception of long-term care (nursing homes, ICF-MR, and Hospice), extended mental health benefits, and organ transplants.
- Beneficiaries needing these excluded services may transfer to the Enhanced Plan if the excluded services become medically necessary.
- Covers new benefits such as preventive services, nutritional services, and the new Preventive Health Assistance.
- For SCHIP eligible individuals, this plan also reduces the scope of inpatient and outpatient mental health benefits and adding dental benefits.

Upon enrollment or annual re-enrollment into Medicaid or SCHIP, enrollees are placed into the Plan that best fits their health needs. Enrollees are given a health screening and placed into a primary care case management system (PCCM). Idaho has three different systems of triggers that move an individual into the Enhanced Plan: physician diagnosis of special health needs; utilization of mental health services up to the limits in the Basic Plan; or receiving certain other forms of assistance from the Idaho Department of Health and Welfare. Any one of these three triggers would move the enrollee into the Enhanced Plan. Both of these benefit packages (Medicaid Basic Plan and Medicaid Enhanced Plan) remain fee for service.

The final benefit plan and enrollment category is for persons eligible for both Medicare and Medicaid who are enrolled in participating Medicare Advantage plans. In an effort to coordinate services with Medicare Part D, Idaho has created a partially capitated system with major insurance carriers that provide Part D services. Idaho will pay a capitated rate per enrollee to carriers for integrated services in addition to Medicare-excluded drugs,

and will also provide fee for service "wrap-around" benefits. The new coordinated plan will begin in Spring 2007.

KENTUCKY

In May 2006, Kentucky received state plan amendment approval from CMS to move forward on plans to redesign its Medicaid program using DRA flexibility. The new plan, KYHealth Choices, offers four different benefit packages tailored to specific populations, increases cost sharing, and expands access to community-based long-term care. The new targeted benefit plans replace the Medicaid benefit package with "Secretary-approved" coverage.

- Kentucky Medicaid will better serve its beneficiaries through better targeting of benefits to meet beneficiary needs, creating incentives for healthy behavior, supporting private coverage, and enhancing the affordability and accountability.
- Through multiple amendments to the Medicaid State Plan, Kentucky has established four benefit packages uniquely tailored to those enrolled in those packages: Global Choices, Family Choices, Comprehensive Choices and Optimum Choices. The benefit plans will not vary the amount, duration and scope of mandatory services.
- Additionally, the Commonwealth is strengthening the existing health insurance coverage by encouraging take-up of employer sponsored insurance through offering a premium assistance option.
- To encourage and promote healthy behaviors among Kentuckians, the Commonwealth will also offer additional limited Get Healthy Benefits, including limited dental and vision service allowances (up to $50 for each), nutrition counseling and meal planning, and smoking cessation therapy and nicotine patch treatment for beneficiaries participating in Disease Management Programs. The DM programs are for individuals with pediatric obesity, pediatric asthma, adult asthma, heart failure and diabetes.

BENEFITS AND ELIGIBILITY

Global Choices

- Global Choices becomes the "regular State Medicaid Plan coverage" in Kentucky for adults.
- Will cover the general Medicaid population program including foster children and medically fragile children.
- Modifications made under two traditional state plan amendments to incorporate cost sharing and benefit limit changes to the Medicaid State plan.
- Limited, nominal cost sharing changes (allowable pre-DRA).
- Service limits: limits to number of visits allowed for occupational therapy, physical therapy, speech therapy, chiropractic services, audiometric services, and other hearing aid dealer services; limits coverage for eyeglasses to one pair per year for recipients under age 21.

- Covers all disabled and elderly populations who do not opt-in to Comprehensive Choices and Optimum Choices.
- Medically necessary services provided in accordance with EPSDT requirements.
- Approximately 235,000 members.

Family Choices

- Will cover most children including SCHIP children.
- State is providing Medicaid coverage through a Secretary-approved benchmark plan under section 1937 of the Social Security Act as added by the Deficit Reduction Act (DRA). The Family Choices benefit package was based on the Kentucky state employee benefit package with modifications to assure nominal cost sharing. Limits imposed under the Family Choices plan are soft limits, which means additional visits will be authorized if medically necessary; in contrast, the limits in the state employee health benefit plan are hard limits and may not be exceeded. The *differences* between the state employee benefit and the Family Choices benefit are detailed in the following table:

State Employee Benefit	**Family Choices Benefit**
Chiropractic Services- 26 per visits per year	Chiropractic Services- 7 visits per year for those under 18 and 15 visits per year for those over 18
Speech Therapy- 30 visits per year	Speech Therapy- 15 visits per year
Physical Therapy- 30 visits per year	Physical Therapy- 15 visits per year
Occupational Therapy- 30 visits per year	Occupational Therapy- 15 visits per year
EPSDT (not fully covered)	EPSDT
Home Health- limited to 60 visits per year	Home Health- no visit limitation
Skilled Nursing Facility Services- limited to 30 days per year	Skilled Nursing Facility Services- no day limitation

- State is mandating enrollment for healthy children in accordance with authority provided under section 1937 of the Act.
- The State has submitted a corresponding State Plan Amendment under SCHIP to mirror the changes.
- This is currently a Fee-for-Service (FFS) delivery system. The State plans to contract with a managed care entity in the future.
- Medicaid eligibles are exempt from copays and co-insurance. Copays apply for the SCHIP children as follows: $2 allergy co-pay, tiered Rx drug copays ($1 generic, $2 preferred, $3 non-preferred brand name prescriptions),$50 hospital inpatient admission, and 5% coinsurance for non-emergency ER use. Maximum out-of-pocket spending is $225 per year for services and $225 a year for

prescriptions. Total cost-sharing cannot exceed 5 percent of a family's total quarterly income. There is some conflicting information on whether KY has exceed DRA provisions by allowing enforceability by the state to deny services to those under 100% of poverty for non-payment, and prohibiting providers from waiving cost sharing on a case-by-case basis.
- Approximately 263,000 members.

Comprehensive Choices and Optimum Choices

- Secretary-Approved Benchmark Plans
- *Individuals who are elderly and in need of a nursing facility level of care (Comprehensive Choices) and individuals with mental retardation and developmental disabilities who meet the ICF/MR level of care (Optimum Choices)* may voluntarily opt-in to the plan; no individuals are required to enroll in either.
- Provides lower co-payments to vulnerable population with special needs including: physician services, vision services, dental services, chiropractic services, and hearing and audiometric services.
- Approximately 263,000 members eligible to opt-in for Comprehensive Choices, and approximately 3,500 members eligible to opt in for Optimum Choices.

SUPPORTING PRIVATE COVERAGE OPTIONS

- Medicaid beneficiaries will now have the option to "opt-in" to private employee sponsored insurance (ESI).
- Only adults are eligible to opt-in to ESI; at this time, children will not have this option.
- The decision to opt-in is solely the beneficiary's choice. If a beneficiary opts-in to ESI, KyHealth Choices will pay the member's portion of their premium.
- The Commonwealth will implement this private coverage component through benchmark-equivalent coverage under section 1937 of the Act. The State will compare employer-sponsored packages to the State Employees Health Benefits Plan and pay premiums if equivalent.
- Medicaid members who chose the ESI option may opt out of ESI and back into the appropriate Medicaid plan at any time.

SOUTH CAROLINA

On March 14, 2007 the State of South Carolina submitted a benchmark SPA to offer beneficiaries the option of enrolling in the South Carolina State Employee High Deductible Health plan. The benchmark State plan option provides States with the opportunity to offer an alternative benefit package to beneficiaries without regard to comparability of services, freedom of choice and state-wideness. This will be beneficial for Medicaid beneficiaries for the following reasons:

- Allows beneficiaries the option to participate in mainstream health insurance in a high deductible health plan;
- Enrollment will promote patient awareness of the high cost of medical care;
- Provides incentives to seek preventive care services;
- Reduces inappropriate use of health care service;
- Engage in a more proactive role in their health care.

BENEFITS AND ELIGIBILITY

- Eligible individuals will be given the opportunity to voluntarily opt into the benchmark coverage to receive the same health benefits that South Carolina State Employees receive.
- Most categorically eligible families and children, as well as individuals in disability-based eligibility groups are eligible to enroll in the benchmark plan.
- Initial implementation will be limited to 1000 beneficiaries who are Richland County residents.
- Beneficiary counselors will assist client selection of appropriate delivery models and will provide a comparison of the alternative plan to the regular Medicaid plan.
- Participants may voluntarily opt out of the benchmark to receive traditional Medicaid coverage at any time.
- South Carolina is providing Medicaid coverage through a State Employee Coverage high deductible health plan option under section 1937 of the Social Security Act as added by the Deficit Reduction Act (DRA).
- The annual deductible amounts are $3000 for an individual and $6000 for family coverage. Beneficiaries are not subject to any cost sharing obligations until the annual deductible has been reached. After the deductible has been met, traditional Medicaid State plan cost sharing requirements apply.
- The State will provide EPSDT services to children under age 19.
- All services will be provided as fee for service.
- South Carolina will implement this benchmark on April 1, 2007.

VIRGINIA

The benchmark plan provides States the opportunity to offer an alternative benchmark benefit package to beneficiaries without regard to comparability of services. This will be beneficial for Medicaid beneficiaries with chronic diseases for the following reasons:

- The benchmark benefits increase the ability of the individuals to follow their providers plans of care and play a more proactive role in their health care;
- The benchmark benefits will assist in managing the utilizations of services by educating participants about their chronic conditions while helping them to become more efficient consumers of the health care system;
- The benchmark services support primary care providers by providing their patients who have chronic conditions with access to a 24-hour nurse help line and referrals to needed services and then providing feedback about patient health

activities back to the primary care providers to help facilitate changes to a patients' plan of care.

BENEFITS AND ELIGIBILITY

- All individuals categorically eligible in the State Medicaid plan that are determined to have asthma, congestive heart failure, coronary artery disease, and/or diabetes may elect to participate in *Healthy Returns*, with the exception of four groups of individuals. The following groups of individuals are not eligible for enrollment in Healthy Returns:
    - Individuals enrolled in Medicaid/FAMIS managed care organizations;
    - Individuals enrolled in both Medicaid and Medicare (dual eligibiles);
    - Individuals who live in institutional settings; and
    - Individuals who have third party insurance.
- Eligible individuals will be given the opportunity to voluntarily opt out of traditional Medicaid coverage and into benchmark coverage. This option will be available Statewide.
- In addition to the traditional State plan services under Medicaid, individuals enrolled in this program will receive additional benefits tailored to specific health needs including:
    - Condition specific education:
    - Access to a 24 hour nurse call line (with access to other licensed health professionals such as pharmacists and nutritionists);
    - Regularly scheduled telephonic health care management and support; and
    - Care coordination including feedback to the primary care physician.
- Virginia is providing Medicaid coverage through a Secretary-approved benchmark plan under section 1937 of the Social Security Act as added by the Deficit Reduction Act.
- The disease management component will be provided through a prepaid ambulatory health plan. All services will be provided as fee for service.
- The State anticipates that 20,000 to 25,000 participants will enroll in the *Healthy*
- *Returns* program.
- Virginia will implement this program as of October 1, 2006.

WASHINGTON STATE

On March 30, 2007, Washington submitted a benchmark SPA request to offer regular Medicaid State plan services plus disease management (DM) services to adult Medicaid recipients with complex medical needs who are diagnosed with certain chronic medical conditions, including: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, and chronic pain associated with musculoskeletal conditions and other chronic illness. The benchmark State plan option provides States with the opportunity to offer an alternative benefit package to beneficiaries without regard to comparability of services. This will be beneficial for Medicaid recipients for the following reasons:

- The benchmark services will assist individuals in locating a medical home (primary care provider (PCP)) and learning to use the PCP appropriately.

- The benchmark benefits increase the ability of individuals to follow their provider's prescribed plan of care and to play a more proactive role in their health care by educating participants about their chronic conditions through education while helping them to become more efficient consumers of the health care system

- The benchmark services support primary care providers by: (1) providing their patients with chronic conditions access to nurse help lines and referrals for needed services; and (2) providing feedback about patient health activities to the primary care providers to help facilitate changes to a patient's plan of care. The benchmark program will help manage the utilization of services.

BENEFITS AND ELIGIBILITY

- All categorically needy aged, blind or disabled adults aged 21 or over currently receiving services via fee-for-service will be offered the opportunity to enroll.

- Eligible individuals will be given the opportunity to voluntarily opt out of traditional Medicaid coverage and opt into the disease management program. Individuals will be identified by a contractor based on claims history, referred by a provider, or may be self-referred. This option will be available statewide.

- The program will be phased in by large groups of clients (1000 per quarter in King County, 4000 per quarter Statewide).

- In addition to the traditional State plan services, individuals enrolled in this program will receive additional benefits tailored to specific health needs, including:

    - o Condition-specific education;
    - o Access to a nurse call line;
    - o Regularly scheduled telephonic health care management and support; and
    - o Care coordination including feedback to the primary care physician.

- Washington is providing Medicaid coverage through a Secretary-approved benchmark plan under section 1937 of the Social Security Act as added by the Deficit Reduction Act (DRA).

- The disease management component will be provided through a prepaid ambulatory health plan. All other services will be provided as fee for service.

- The State anticipates that 15,000 participants will ultimately enroll in the disease management program.

- Washington will implement this disease management program as of January 1, 2007.

WEST VIRGINIA

This state plan amendment implements section 6044 of the Deficit Reduction Act of 2006 (DRA) to provide Secretarial approved benchmark benefit packages for Medicaid eligibles, except those exempted under section 1937 of the Social Security Act (the Act).

The SPA includes these key features:

- This population is primarily the healthy adults and children.
- The benchmark benefits are comparable to the minimum required Medicaid benefit package and they include Early, Periodic, Screening Diagnosis and Treatment (EPSDT) services for children.
- In accordance with section 1937 of the Act, the individuals will be mandated into the basic benefit package.

SPECIAL FEATURES

This innovative reform program creates the opportunity for beneficiaries to obtain optional benefits using the partnership agreement between the beneficiary, the medical home and the State.

Unique to this program are the following features:

- Upon enrollment, individuals will choose, or be assigned to a medical home and will be counseled about obtaining and receiving appropriate health services.
- Individuals electing to sign a membership agreement, which focuses on appropriate health and wellness programs, and beneficiary, provider, and State rights and responsibilities rewards participation by providing enhanced benefits targeted to the specific health needs of the individual.

ELIGIBILITY

- Approximately 50 percent of the State's Medicaid beneficiaries will be able to participate in the program once it is completely phased in (three rural counties are first to implement). It is estimated that approximately 160,000 beneficiaries will be affected at the completion of the phase in.
- These Medicaid beneficiaries are generally healthy adults and healthy children on Medicaid. These include individuals receiving assistance through Temporary Assistance for Needy Families (TANF) or are TANF-related individuals. Disabled and elderly individuals **are not** included in this reform plan at this time.

BENEFITS AND MEMBER AGREEMENTS

- Individuals electing to sign a membership agreement, which focuses on appropriate health access to a medical home, will be provided enhanced benefits targeted to the specific health needs of the individual.
- A basic and enhanced benefit package is available to healthy adults and children rendering two choices for each group rewarding personal responsibility related to health care. *The basic benefit packages provide all mandatory Medicaid services, as well as age appropriate optional services such as limited vision, dental and hearing for children, and family planning for adults.*
- An enhanced benefit package is available after a beneficiary signs a member agreement. *The enhanced benefit packages also provide all mandatory Medicaid services, with the addition many optional age appropriate services that focus on wellness. Examples of these services include cardiac rehabilitation, tobacco cessation programs and chiropractic services for adults, and nutritional education, chemical dependency and mental health services for children.*
- To continue receiving enhanced services, the member must:
    - Receive screenings as directed by the health care provider;
    - Adherence to health improvement programs as directed by their health care provider;
    - Attending scheduled appointments; and
    - Taking medication as directed by their health care provider.
- Members will have to adhere to their member agreement and will have appeal rights prior to being moved from the enhanced benefit package to the basic benefit package for non-compliance.
- Other than at the programs' inception, beneficiaries are offered additional chances to "sign up" for healthy behaviors through the member agreement (once a year). At the time of redetermination, each beneficiary will have the option to commit to the member agreement, thereby gaining or regaining access to the enhanced benefit package.

DELIVERY SYSTEM

- The planned delivery system for the program is managed care, or a managed care fee-for service mix. Services will be delivered in the medical home, which will consist clinics as well as provider offices.
- The delivery system for each of the geographic areas will be determined as the program is phased in.
- West Virginia plans to phase in the Benchmark Benefits program beginning in Clay, Upshur and Lincoln counties. The anticipated implementation date for these counties is July 1, 2006.

West Virginia has plans to implement additional changes to the Medicaid program in January 2008. These include the creation of "Healthy Rewards Accounts." Because these changes are still months away from implementation, specifics are yet to be determined. The general intention is that under this program, individuals earn points for

following their personal health improvement plans, going to all their doctor's appointments, and using services appropriately. Individuals can also lose points, for example by getting a brand name prescription drug when an equivalent generic drug was available, or for using the emergency room inappropriately. Individuals can then use their accumulated points to access services that are usually unavailable to them, such as dental services or vision benefits.